

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Florida</b> b. COUNTY <b>Dade</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIAMI</b>	
c. LENGTH OF STAY IN 1b <b>3 months</b>		d. STREET ADDRESS <b>276 NW 6th St</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13th &amp; Boardwalk</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Andrew (None) Askew</b>		4. DATE OF DEATH <b>August 25 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Approx 1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bellman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Archie Askew</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>262-05220</b>	
17. INFORMANT <b>Robert Archie Adams</b>		Address <b>1702 Calhoun St Jacksonville Florida</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic CVD</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 8 1956</b> , to <b>Aug 25 1956</b> , that I last saw the deceased alive on <b>Aug 8 1956</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. J. Townsend, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Ocean City, Md.</b> DATE SIGNED <b>Aug 25, 56</b>	
PHYSICIAN'S NAME (Type) <b>F. J. Townsend Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>8-29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Denville Washington Co. Ga</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 30 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Helen E. Hayward</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

AUG 30 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

## CERTIFICATE OF DEATH

Reg. Dist. No.

88831 356

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route #2</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jeffery</b> Middle <b>Andrew</b> Last <b>Bratten</b>				4. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>A.A.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 15 56</b>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 24 HRS. Days <b>4</b> Hours <b>4</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>USA Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Bratten</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Purnell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William H. Bratten, Berlin, Md. Rt # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>8/15</b> , 19 <b>56</b> , to <b>8/19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8/18</b> , 19 <b>56</b> , and that death occurred at <b>4:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Loory U. Shely Jr.</b>				ADDRESS (Street, city or town, state) <b>Berlin Md</b>		DATE SIGNED <b>8/21/56</b>	
PHYSICIAN'S NAME (Type) <b>Loory U. Shely Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-20-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Md Rt #2</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b>				24a. REC'D BY REGISTRAR <b>AUG 22 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John F. Stewart</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1890</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>8-15-1956</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Immediate cause: <u>MYOINFARCTION</u></p>	
<p>9. Duration of illness: <u>2 WEEKS</u></p>		<p>10. Usual place of abode: <u>HOME</u></p>	
<p>11. Name of physician: <u>DR. J. H. SMITH</u></p>		<p>12. Name of funeral home: <u>JOHN J. SMITH</u></p>	
<p>13. Name of informant: <u>JOHN J. SMITH</u></p>		<p>14. Signature of informant: <u>[Signature]</u></p>	
<p>15. Name of registrar: <u>JOHN J. SMITH</u></p>		<p>16. Signature of registrar: <u>[Signature]</u></p>	

BUREAU V. 1

AUG 22 1956

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8841  
CERTIFICATE OF DEATH

08832  
Reg. Dist. No. 355

1. PLACE OF DEATH o. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. LENGTH OF STAY IN 1b 40yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY	
		d. STREET ADDRESS BALTIMORE AVE	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SADIE CAREY		4. DATE OF DEATH Month Day Year AUG 4 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1897
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL CROPPER		14. MOTHER'S MAIDEN NAME AMELIA LYNCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. CLARENCE CAREY		Address OCEAN CITY, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Acute Arterio Sclerotic (CVD) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1947, to AUG 4 1956, that I last saw the deceased alive on AUG 4 1956, and that death occurred at 11 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Ocean City, Md Aug 6 56	
ACTUAL SIGNATURE F. J. Townsend, Jr. M.D.		PHYSICIAN'S NAME (Type) F. J. TOWNSEND Jr. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/7/56	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BERLIN MD	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burban		ADDRESS Berlin Md	
24a. REC'D BY REGISTRAR DATE 8/7/56		24b. REGISTRAR'S SIGNATURE Helen F. Hayward	



CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
RESIDENT OF		DECEASED	
MARRIED TO		SEX	
BORN		AGE	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER OF THE GOSPEL	
SIGNATURE OF CLERK		SIGNATURE OF JURY	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF SECRETARY OF HEALTH	

BUREAU V. E.

MAY 13 1956

RECEIVED

8845

CERTIFICATE OF DEATH

088331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Parker</u> Last <u>Cherish</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13 - 1861</u>
9. AGE (In years last birthday) <u>94</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>19</u> Hours <u>29</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Stockton, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Cherish</u>		14. MOTHER'S MAIDEN NAME <u>Bessie, Duber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John E. Cherish</u>		Address <u>Stockton, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> 490.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>490.X</u> DUE TO (c) <u>5 weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 4</u> , 19 <u>56</u> , to <u>Aug. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 8</u> , 19 <u>56</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas L. Jones, M.D.</u>		DATE SIGNED <u>8/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Stockton, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton L. Jones, Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 13 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Clayton L. Jones</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 1

AUG 13 1956

RECEIVED



## INSTRUCTIONS

**1** **1** **1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8845

## CERTIFICATE OF DEATH

08834

Reg. Dist. No. 351

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>Snow Hill</i>		<i>Rundt #1 68 yrs</i>		TOWN <i>Snow Hill</i>		<i>Rundt #1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>George Z. Dale</i>				<i>Aug. 29 1956</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<i>Male</i>	<i>Colored</i>	<i>Married</i>	<i>Sept. 10/1887</i>	<i>68 11/19</i> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Farmer</i>				<i>Snow Hill, md</i>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>Harry Dale</i>				<i>Amy Bowery</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT &amp; ADDRESS</b>			
<i>No</i>			<i>None</i>	<i>Miss Sattin Dale, Snow Hill, md</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>434.1 IMMEDIATE CAUSE (A)</b>				<i>Congestive Heart Failure</i>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B)							
<b>DUE TO</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8/22, 1956, to 8/29, 1956, that I last saw the deceased alive on 8/28, 1956, and that death occurred at 1:00 P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Thomas L. Jones, M.D.</i>				<b>DATE SIGNED</b> <i>8/30/56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<i>Burial</i>		<i>Sept. 1/30</i>		<i>West Wesley</i>		<i>Snow Hill, md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>Aug 31 1956</i>		<i>Clayton Cooper</i>		<i>Clayton Cooper</i>		<i>Snow Hill, md</i>	

# CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Race: \_\_\_\_\_

7. Occupation: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Date of death: \_\_\_\_\_

10. Place of death: \_\_\_\_\_

11. Signature of physician: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_

13. Signature of informant: \_\_\_\_\_

14. Signature of witness: \_\_\_\_\_

15. Signature of funeral director: \_\_\_\_\_

16. Signature of undertaker: \_\_\_\_\_

17. Signature of cemetery: \_\_\_\_\_

18. Signature of burial: \_\_\_\_\_

19. Signature of interment: \_\_\_\_\_

20. Signature of cremation: \_\_\_\_\_

21. Signature of other: \_\_\_\_\_

22. Signature of other: \_\_\_\_\_

23. Signature of other: \_\_\_\_\_

24. Signature of other: \_\_\_\_\_

25. Signature of other: \_\_\_\_\_

26. Signature of other: \_\_\_\_\_

27. Signature of other: \_\_\_\_\_

28. Signature of other: \_\_\_\_\_

29. Signature of other: \_\_\_\_\_

30. Signature of other: \_\_\_\_\_

31. Signature of other: \_\_\_\_\_

32. Signature of other: \_\_\_\_\_

33. Signature of other: \_\_\_\_\_

34. Signature of other: \_\_\_\_\_

35. Signature of other: \_\_\_\_\_

36. Signature of other: \_\_\_\_\_

37. Signature of other: \_\_\_\_\_

38. Signature of other: \_\_\_\_\_

39. Signature of other: \_\_\_\_\_

40. Signature of other: \_\_\_\_\_

41. Signature of other: \_\_\_\_\_

42. Signature of other: \_\_\_\_\_

43. Signature of other: \_\_\_\_\_

44. Signature of other: \_\_\_\_\_

45. Signature of other: \_\_\_\_\_

46. Signature of other: \_\_\_\_\_

47. Signature of other: \_\_\_\_\_

48. Signature of other: \_\_\_\_\_

49. Signature of other: \_\_\_\_\_

50. Signature of other: \_\_\_\_\_

51. Signature of other: \_\_\_\_\_

52. Signature of other: \_\_\_\_\_

53. Signature of other: \_\_\_\_\_

54. Signature of other: \_\_\_\_\_

55. Signature of other: \_\_\_\_\_

56. Signature of other: \_\_\_\_\_

57. Signature of other: \_\_\_\_\_

BUREAU V. 5

AUG 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8847

## CERTIFICATE OF DEATH

08835

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whaleyville</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXX</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whaleyville</b>			
				d. STREET ADDRESS <b>XXX</b>			
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>A.</b> Last <b>DALE</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan, 1 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Dale</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
14. MOTHER'S MAIDEN NAME <b>Ki tty Whaley</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>X</b>		16. SOCIAL SECURITY NO. <b>X</b>		17. INFORMANT <b>Hayward Dale</b>		Address <b>Whaleyville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Myocarditis - acute</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Nephritis</b> DUE TO (c) <b>Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>56</b> , to <b>Aug 12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Aug 11</b> , 19 <b>56</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas R. Law</b> M.D.				ADDRESS (Street, city or town, state) <b>Burlier 714</b> DATE SIGNED <b>8-13-56</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 15, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pullets Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Whaleyville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley</b>				24a. REC'D BY REGISTRAR <b>17 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas F. Hayward</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
MARRIED		JULY 1, 1966		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		ATTORNEY	
EDUCATION		SCHOOLING		RELIGION		PREVIOUS ILLNESS		TREATMENT		HISTORY	
HIGH SCHOOL		HIGH SCHOOL		METHODIST		NONE		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		SIGNATURE	
JULY 1, 1966		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		ATTORNEY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		SIGNATURE	
JULY 1, 1966		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		ATTORNEY		JAMES EARL RAY	

**RECEIVED**  
AUG 17 1966  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8848 CERTIFICATE OF DEATH									
Reg. Dist. No. 88836 357									
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>					d. STREET ADDRESS <u>411 Tingle St.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>GINN</u> Last <u>GINN</u>					4. DATE OF DEATH Month <u>AUG.</u> Day <u>15</u> Year <u>1956</u>				
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
						IF UNDER 1 YEAR		IF UNDER 24 HRS.	
						Months		Days	
						Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>				
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>RALEY GINN</u>					14. MOTHER'S MAIDEN NAME <u>SARAH SELBY</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Horace Ginn</u> Address <u>411 Tingle St. Snow Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic disease</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>1954</u> , 19 _____, to <u>8/15/56</u> , 19 _____, that I last saw the deceased alive on <u>8/14/56</u> , 19 _____, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.					ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u> DATE SIGNED <u>8/16/56</u>				
PHYSICIAN'S NAME (Type) <u>DR. PAUL COHEN</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown</u>			22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>New Church, Va.</u>					24a. REC'D BY REGISTRAR <u>Aug 15, 56</u>		24b. REGISTRAR'S SIGNATURE <u>Ray E. Cooper</u>		



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. 5

AUG 21 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08837

355

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Thomas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PAVO (Rural)</u> 49x3	
c. LENGTH OF STAY IN 1b <u>3 weeks</u>		d. STREET ADDRESS <u>Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 113</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Graham</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1906</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Dalston Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dan Graham</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Danton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>James Graham</u>		Address <u>Pavo Georgia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation with Pulmonary Edema</u> 422.1 DUE TO <u>Arteriosclerotic (VD)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>F. J. Townsend</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. TOWNSEND</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Houston Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 31 1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, race, date of death, place of death, and a large section for the medical examiner's findings and signature.

BUREAU V. 11

AUG 31 1956

RECEIVED

## 8853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 202 8-30-56 et

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. LENGTH OF STAY IN 1b <u>7 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street, address) <u>Belmont Hotel</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS FRANCIS HEALY</u>		4. DATE OF DEATH <u>August 23 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 31, 1912</u>
9. AGE (in years last birthday) <u>44 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS HEALY</u>		14. MOTHER'S MAIDEN NAME <u>HELEN FERRER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MRS. ELIZABETH LEFFSON</u>		Address <u>6505 44th Ave N.W. UNIVERSITY PARK MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease E</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Thrombosis</u> (c) <u>Coronary thrombosis &amp; insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u> <u>6-8 hours</u> <u>4-5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kypho-scoliosis sec to Polio myelitis in childhood</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Herman A. Robbins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HERMAN A. Robbins M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>8/23/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce R. Busby</u>		ADDRESS <u>Quilins Rd</u>	
24a. REC'D BY REGISTRAR <u>Aug 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Hayward</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 3

AUG 24 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8851

CERTIFICATE OF DEATH

08839

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>ST. MARTINS (RURAL)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIDA</u> <u>CORDELIA</u> <u>HOLLAND</u>		4. DATE OF DEATH Month Day Year <u>Aug</u> <u>1</u> <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 18, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN V. DENNIS</u>		14. MOTHER'S MAIDEN NAME <u>HETTY CATHERING TIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. BESSIE HOLLAND, BERLIN, MD</u>		Address <u>USA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>443X</u> DUE TO <u>myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u> <u>19</u>		20d. INJURY OCCURRED While <u>None</u> at work <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>56</u> , to <u>Aug 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 30</u> , 19 <u>56</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D. <u>Berlin Md.</u> PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT MD</u> <u>BERLIN MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/4/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burboys, Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/5/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Helen F Hayward</u>			

CERTIFICATE OF DEATH

1700 1

acute myocardial infarction  
myocardial  
infarction

None

None

None

None

July 12 1956

BUREAU V. E.

Clifford E. Schott

Baltimore, Md.

AUG 2 1956

CLIFFORD E. SCHOTT MD BALTIMORE MD

RECEIVED

8852

09805

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

Reg. Dist.

## 1. PLACE OF DEATH:

COUNTY Worcester MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Berlin  
 LENGTH OF STAY (In this place) 3 WEEKS  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE PA COUNTY LANCASTER  
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN ROCKRESTOWN PA  
 STREET ADDRESS (If rural, give location) 75X-3

3. NAME OF DECEASED: (First) (Middle) (Last)  
EUGENE KANE HORST  
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)  
August 1 1956

5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED 8. DATE OF BIRTH: OCT. 2, 1932 9. AGE last birthday: 23 yrs.  
 IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): SILVER SMELTER 10b. KIND OF BUSINESS OR INDUSTRY: SILVER REFINING 11. BIRTHPLACE (State or foreign country): LANCASTER Co. PA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

WILLIAM K. HORST

## 14. MOTHER'S MAIDEN NAME:

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

MRS. E. K. HORST, ROCKRESTOWN, PA

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

105 min

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Berlin Worcester Co Md 21c. (City or town) (County) (State)  
 CAUSE OF DEATH.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Aug 1 1956 3 PM 21e. INJURY OCCURRED While at work ☒ Not while at work ☐ 21f. HOW DID INJURY OCCUR? Fell off scaffolding

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Herman G. Radwin M.D.

CHIEF MEDICAL EXAMINER  
 DEPUTY MEDICAL EXAMINER  
 ASSISTANT MEDICAL EXAM. DATE SIGNED 8/1/56

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL DATE THEREOF 8/4/56 NAME OF CEMETERY OR CREMATORY QUARRVILLE PA LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 8/2/56 REGISTRAR'S SIGNATURE Helen F. Hayward 24. FUNERAL DIRECTOR Anna D. Burby Berlin Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

MUG 3 1956

RECEIVED

10/1/56

8853

## CERTIFICATE OF DEATH

Reg. Dist. No. 357

08841

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOCKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>				d. STREET ADDRESS <u>STOCKTON, MD.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>MASON</u> Last <u>MASON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COI.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN MASON</u>				14. MOTHER'S MAIDEN NAME <u>Ester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Philmore Mason - STOCKTON, MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 7</u> , 19 <u>56</u> , to <u>Aug. 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 1</u> , 19 <u>56</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>				ADDRESS (Street, city or town, state) <u>325 Market St. Annapolis, MD</u> DATE SIGNED <u>8/13/56</u>			
PHYSICIAN'S NAME (Type) <u>Thomas L. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>1st. HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug 16, 56</u>		24b. REGISTRAR'S SIGNATURE <u>August E. Cooper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

321

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

BUREAU V. S.

AUG 21 1956

RECEIVED

Handwritten signature or initials at the bottom of the page.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **88841-555**

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Florida</b> b. COUNTY <b>Dade</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Ocean City</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ELM St &amp; DUAL Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>RICHARD</b> Middle <b>MELVIN</b> Last		4. DATE OF DEATH Month <b>Aug</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24 1929</b>
9. AGE (In years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.	11. IF UNDER 24 HRS. Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transport</b>	
11. BIRTHPLACE (State or foreign country) <b>Chincoteague, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES CARPENTER MELVIN</b>		14. MOTHER'S MAIDEN NAME <b>LUCY FLORENCE COONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>AIR FORCE 1945-1946</b>		16. SOCIAL SECURITY NO. <b>181 22 3712</b>	
17. INFORMANT <b>PAUL MELVIN</b>		Address <b>Ocean City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound head</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>PLAYING RUSSIAN ROULETTE</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>PLAYING RUSSIAN ROULETTE</b>		20c. TIME OF INJURY Month, Day, Year <b>July 31 1956</b>	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STORE</b>	
20f. (City or town) <b>Ocean City</b>		(County) <b>W.D.</b>	
20g. (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <b>F J TOWNSEND JR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>F J TOWNSEND JR</b>		DATE SIGNED <b>AUG 3, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>8/6/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SILVER BROOKE CEM</b>		22d. LOCATION (City, town, or county) <b>WILMINGTON DEL.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna R. Burbage</b>		ADDRESS <b>Berlin Md</b>	
24a. REC'D BY REGISTRAR <b>DATE 8/5/56</b>		24b. REGISTRAR'S SIGNATURE <b>Helen F Hayward</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 7 1956

BUREAU V. M.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18842

Reg. Dist. No. 255

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Worcester</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Wicomico</b></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Berlin</b>			c. LENGTH OF STAY IN 1b 										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>South Point (Bay)</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>FLOYD NORMAN POWELL</b>				<b>4. DATE OF DEATH</b> Month <b>Aug.</b> Day <b>23</b> Year <b>1956</b>									
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Aug. 13, 1926</b>		<b>9. AGE</b> (In years last birthday) <b>30</b> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Plumbing</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Hebron, Maryland</b>									
<b>13. FATHER'S NAME</b> <b>James W. Powell</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Virgie Mae Bailey</b>										
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <span style="float: right;">(If yes, give war or dates of service) <b>W.W. II</b></span>		<b>16. SOCIAL SECURITY NO.</b> <b>218-20-7830</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mr. James W. Powell (Father) Parsonsburg, Maryland</b>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Suffocation due to drowning</b>  <b>929.9</b>  <b>DUE TO</b> </td> <td style="width: 70%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>minutes</b> </td> </tr> <tr> <td> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>DUE TO</b> </td> <td></td> </tr> </table>					<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Suffocation due to drowning</b> <b>929.9</b> <b>DUE TO</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>minutes</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>				
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Suffocation due to drowning</b> <b>929.9</b> <b>DUE TO</b>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>minutes</b>												
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> <span style="float: right;">(County) (State)</span>										
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <b>Herman A. Robbins</b> M.D. <span style="float: right;">CHIEF MEDICAL EXAMINER <input type="checkbox"/></span>				<b>DATE SIGNED</b> <b>8/24/56</b>									
<b>EXAMINER'S NAME (Type)</b> <b>Herman A. Robbins</b> <span style="float: right;">ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></span>				<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Aug. 26, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Parsonsk Cemetery</b>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>DATE 8/28/56 Helen Hayward</b>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the cause in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. (Rev)		Male		30		Aug 11, 1956	
Place of Birth		Place of Death		Cause of Death		Manner of Death	
Boston, Mass		Boston, Mass		Heart Disease		Natural	
Occupation		Residence		Physician		Hospital	
Teacher		1234 Main St		Dr. J. J. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

AUG 28 1956

RECEIVED



8840

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peacock Hotel				d. STREET ADDRESS 109 Willow St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HERBERT SMITH, Jr.				4. DATE OF DEATH Month Day Year August 19, 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1897	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Appliances		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Smith, Sr.				14. MOTHER'S MAIDEN NAME Marie E. Drew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 218-05-1333		17. INFORMANT Address Florence E. Smith, Pocomoke, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LUETIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 30 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 1, 19 56, to AUGUST 19, 19 56, that I last saw the deceased alive on AUGUST 19, 19 56, and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton		M.D. Pocomoke City MD		DATE SIGNED 8-20-56		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) C. Stanford Hamilton		Pocomoke, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/56		22c. NAME OF CEMETERY OR CREMATORY Presbyterian		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Watson				24a. REC'D BY REGISTRAR DATE 22 1956		24b. REGISTRAR'S SIGNATURE Anne White	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
SMOKING HISTORY		ALCOHOL HISTORY	
DRUG HISTORY		ALLERGIC HISTORY	
VACCINATION HISTORY		LABORATORY TESTS	
X-RAY		PATHOLOGICAL FINDINGS	
MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
VIRUS FINDINGS		PARASITOLOGICAL FINDINGS	
IMMUNOLOGICAL FINDINGS		CYTOLOGICAL FINDINGS	
GENETIC FINDINGS		ENVIRONMENTAL FINDINGS	
DIETARY HISTORY		EXERCISE HISTORY	
STRESS HISTORY		SUBSTANCE ABUSE HISTORY	
MENTAL HISTORY		PHYSICAL ABILITY	
VITALITY		MORALITY	
CHARACTER		TEMPERAMENT	
HABITS		INTERESTS	
HOBBIES		PASTIMES	
FRIENDS		RELATIVES	
SOCIAL LIFE		CAREER	
FINANCIAL STATUS		LEGAL STATUS	
MILITARY SERVICE		CIVILIAN SERVICE	
AWARDS		HONORS	
REMARKS		SIGNATURE	
DATE		PLACE	

BUREAU V. E.

AUG 22 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Aug 13 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8857

## CERTIFICATE OF DEATH

08845

Reg. Dist. No. 357

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill, Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS <u>407 Covington Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Henrietta G. Waters</u>				4. DATE OF DEATH (Month) <u>August</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>G.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 24 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Martin</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>201-07-1935</u>		17. INFORMANT & ADDRESS <u>Edgar W. Horton, 407 Covington St. Snow Hill, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
174X IMMEDIATE CAUSE (A) <u>Carcinoma of uterus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Aug 7, 1956</u> , that I last saw the deceased alive on <u>7/15/56</u> and that death occurred at <u>Snow Hill, Md.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edgar W. Horton</u>				DATE SIGNED <u>Aug 9/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Tinsley Chapel Cem.</u>		LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Aug 9, 1956</u>		REGISTRAR'S SIGNATURE <u>Edgar W. Horton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar W. Horton</u>			



22

BUREAU V. M.

1956 21 AUG

RECEIVED

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8841

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>43 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>402 Laurel Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>H.</u> Last <u>Wessells</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1867</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John W. Wessells</u>				14. MOTHER'S MAIDEN NAME <u>Laura Fenton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Purla Anna Wessells, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis multiple</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis, generalized</u> DUE TO (c) <u>Aging process</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, healed</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>20 July</u> , 19 <u>50</u> , to <u>August 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 August 19 56</u> , and that death occurred at <u>  </u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. E. Sartorius, Jr.</u> M.D.				DATE SIGNED <u>Pocomoke, Md.</u>			
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius, Jr.</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Goodwill M.E. Cemetery Rural- Pocomoke, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u>	
24b. REGISTRAR'S SIGNATURE <u>Anne White</u>				DATE <u>8/28/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

AUG 28 1956

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## CERTIFICATE OF DEATH

Reg. Dist. No.

188847  
355

8858

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>80 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>RURAL</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN WILMER JACKSON WHITTINGTON</u>				4. DATE OF DEATH <u>Aug. 19, 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 29, 1875</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN R. WHITTINGTON</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA EMILY PARSONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS. J.W. WHITTINGTON BERLIN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr Nephritis</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 1 - 1956</u> to <u>Aug 19, 1956</u> that I last saw the deceased alive on <u>Aug 19, 1956</u> , and that death occurred on <u>Aug 19, 1956</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>8-20-56</u>							
ACTUAL SIGNATURE <u>Chas R. Law</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Anna R. Burbage Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Kelen F. Hayward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

AUG 24 1956

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